

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676095	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/13/2024
NAME OF PROVIDER OR SUPPLIER West Oaks Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3200 W. Slaughter Lane Austin, TX 78748	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47065 Based on observation, interviews, and record reviews, the facility failed to implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for 1 (Resident #1) of 6 residents reviewed for comprehensive care plans. The facility failed to have a fall mat at Resident #1's bedside while he was lying in his bed. This deficient practice could place residents at risk of not receiving the care and services noted in their care plans. Findings include: Record review of Resident #1's Admission Record, dated 05/09/24, revealed he was initially admitted on [DATE], readmitted [DATE], was his own RP, and diagnosed with diffuse traumatic brain injury without loss of consciousness, conversion disorder with seizures or convulsions, unspecified bipolar disorder, need for assistance with personal care, cognitive communication deficit, repeated falls, and generalized muscle weakness. Record review of Resident #1's Comprehensive MDS Assessment, dated 03/22/24, revealed he had a BIMS score of 00, which indicated he had severe cognitive impairment. Resident #1 had no fall history since admission or readmission. Resident #1 was dependent on staff for assistance with toileting, bed mobility, and transfers. Record review of Resident #1's Care Plan revealed the following note, [Resident #1] had an actual fall 03/30/24 - Resident noted on floor beside bed, 2 red areas to left FH. Resident #1 had one of the following interventions assigned to nursing staff, 3/30/24-Floor mat at bedside. Record review of Resident #1's Fall Risk Evaluation, dated 05/07/24 at 2:01 p.m., revealed he was at high risk for falls because he was disoriented, regularly incontinent, had 3 or more falls in the past 3 months, poor vision, balance problem while standing/walking, 1-2 predisposing conditions, and took 1-2 high risk medications and/or within the last 7 days. (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation and interview on 05/09/24 at 10:00 a.m., revealed Resident #1 was lying in his bed. Resident #1's fall mat was not at bedside. The fall mat was on the ground and across from Resident #1's bed. During an interview, Resident #1 stated the fall mat had been left in the position the surveyor observed, he did not know how long the fall mat been in the position the surveyor observed, he did not know why the fall mat was in the position the surveyor observed, he knew the fall mat was supposed to be at bedside, and he did not notify staff about the fall mat position. Resident #1 also stated he fell daily, and staff would leave him on the ground and not help him. Resident #1 did not elaborate on occurrences in which staff left him on the ground and did not help him. An observation on 05/09/24 at 10:08 a.m., revealed Resident #1 pressed his call light. An observation on 05/09/24 at 10:11 a.m., revealed CNA A answered Resident #1's call light. CNA A repositioned Resident #1's fall mat to his bedside. During an interview on 05/09/24 at 10:12 a.m., CNA A revealed she checked on residents every one or two hours and fall risk residents every two hours. CNA A stated she documented completing all her rounds at the end of her shift in residents' POC. CNA A stated she was responsible for checking on residents who resided in rooms in the first half of the hallway in which Resident #1 resided on. CNA A stated she last checked on Resident #1 at 9:00 a.m. CNA A stated she did not know Resident #1's fall mat was away from his bed. CNA A explained Therapy staff put Resident #1 in bed after his therapy session. CNA A stated she was trained and in-serviced on falls. CNA A stated she was trained on falls last week by one of the two ADONs, which she learned how to respond when a resident falls and ensuring fall mats were next to residents' beds when residents were lying in bed. CNA A stated residents' health and safety could be affected if residents were at risk of falling, lying in bed and did not have a fall mat next to their bed. During an interview on 05/09/24 at 10:24 a.m., CNA B revealed she checked on residents every two hours and constantly and fall risk residents every hour. CNA B stated she documented completing all her rounds throughout her shift in residents' POC. CNA B stated she was responsible for checking on residents who resided in rooms in the second half of the hallway in which Resident #1 resided on. CNA B stated she last checked on residents at 9:30 a.m. CNA B stated she did not check on Resident #1 because she did not work on the first half of the hallway in which Resident #1 resided on. CNA B stated she was trained and in-serviced on falls. CNA B stated residents' health and safety could be affected if residents were at risk of falling, lying in bed and did not have a fall mat next to their bed because they could hurt themselves. During an interview on 05/09/24 at 10:44 a.m., RN C revealed she checked on residents and fall risk residents every hour. RN C stated she worked on two hallways, one of which was the hallway Resident #1 resided on. RN C stated she documented assessments she completed on residents throughout her shift. RN C stated residents' health and safety could be affected if residents were at risk of falling, lying in bed and did not have a fall mat next to their bed. RN C stated nurse staff were responsible for ensuring fall risk residents' fall mats were next to residents' beds if residents were lying down. RN C stated she did not know Resident #1's fall mat was away from his bed. RN C stated she last checked on residents at 9:00 a.m. RN C stated she was trained and in-serviced on falls. During an interview on 05/09/24 at 12:24 p.m., PT D revealed Resident #1 had physical therapy on 05/09/24 between 9:00 a.m. through 10:00 a.m. PT D stated when therapy staff brought Resident #1 back into his room, Resident #1's fall mat was next to his bed. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/09/24 at 12:40 p.m., ADON E revealed she, ADON F, and the DON in-serviced staff on falls. ADON E stated staff were in-serviced weekly. ADON E stated staff were in-serviced on falls within last week, which specifically discussed lowering beds and fall mat placement. ADON E stated residents' fall mats should be next to the bed if residents were lying in their beds. ADON E stated she expected staff to check and ensure residents' fall mats were next to their beds. ADON E stated residents' health and safety could be affected if residents were at risk of falling, lying in bed and did not have a fall mat next to their bed. ADON E stated staff checked on residents every two hours. ADON E stated CNAs documented checking on residents in POC and nurses documented in the administration record and nurse's notes. ADON E stated she was responsible for two halls, one of which was a hall that Resident #1 resided on. ADON E stated she did not know Resident #1's fall mat was not next to his bed because she recently changed to being responsible for two halls in which Resident #1 did not reside on. ADON E stated ADON F worked with Resident #1 a lot. During an interview on 05/09/24 at 2:10 p.m., ADON F revealed she trained and in-serviced staff on falls. ADON F stated staff were in-serviced on falls two weeks ago, which covered fall mat placement on floor and repositioning. ADON F stated she expected staff to check on residents every two hours. ADON F stated CNAs documented checking on residents in POC and nurses documented in POC and nurse's notes. ADON F stated she expected staff to check and ensure residents' fall preventative devices were properly placed on the floor. ADON F stated residents' fall mats should be next to their beds when residents were lying in their beds. Residents' health and safety could be affected if residents were at risk of falling, lying in bed and did not have a fall mat next to their bed. During an interview on 05/09/24 at 2:40 p.m., DON revealed she trained and in-serviced staff on falls. DON stated she expected nursing staff to check on residents throughout their shifts and every two hours, which was best practice. DON stated nursing staff documented in POC whenever they provided a care or service to a resident. DON stated she expected staff to ensure fall risk residents' beds were low and fall mats were placed at bedside. DON stated residents' fall mats should be at bedside if they were lying in bed. DON stated residents' health and safety could be affected if residents were at risk of falling, lying in bed and did not have a fall mat next to their bed. During an interview on 05/09/24 at 3:55 p.m., ADON F revealed there was no policy and procedure for rounding on residents. During an interview on 05/09/24 at 3:56 p.m., MDS G revealed she was trained and in-serviced on falls. MDS G stated residents' health and safety could be affected if residents were at risk of falling, lying in bed and did not have a fall mat next to their bed according to their care plan, which was not following the care plan. During an interview on 05/09/24 at 4:33 p.m., ADM revealed he expected residents who were at risk for falls and lying in bed to have floor mats on the ground next to their beds. During an interview on 05/13/24 at 1:53 p.m., LVN H revealed she checked on residents every hour. LVN H stated residents' fall mats should be next to their beds if residents were lying in their beds. LVN H stated residents' health and safety could be affected if residents were at risk of falling, lying in bed and did not have a fall mat next to their bed. Record review of Resident #1's Kardex Report, dated 05/09/24, revealed staff were required to place floor mat at bedside as of 03/30/24 for Resident #1's safety. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's Incident Log, dated 05/09/24, revealed Resident #1 had a fall on 03/30/24 at 7:07 a.m., 04/09/24 at 12:55 p.m., 04/18/24 at 5:35 p.m., 04/24/24 at 10:02 a.m., and 04/26/24 at 2:46 a.m. Record review of the facility's In-Services Training Reports, from 04/01/24 through 05/13/24 revealed staff did not have any trainings related to implementing care plan interventions and falls. Record review of the facility's Comprehensive Person-Centered Care Planning Policy and Procedure, revised 12/2023, revealed the following, The facility IDT will develop and implement a comprehensive person-centered, culturally-competent, and trauma-informed care plan for each resident within seven days of completion of the MDS and will include resident's needs identified in the comprehensive assessment, any specialized services as a result of PASARR recommendation, and resident's goals and desired outcomes, preferences for future discharge and discharge plan. Record review of the facility's Nursing Services - ADLs Policy and Procedure, revised 05/2007, revealed the following, Each resident receives or is provided the necessary care and services enabling him/her to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehension assessment and plan of care. Each resident receives adequate supervision and assistive devices as needed.		